DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT
MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

A. COMPLETE FOR ALL ESRD PATIENTS

Check one: ☐ Initial ESRD ☐ Re-entitlement ☐ Supplemental

1. Name *(Last, First, Middle Initial)*

2. Health Insurance Claim Number

3. Social Security Number

4. Patient Mailing Address *(Include City, State and Zip)*

5. Phone Number
( )

6. Date of Birth
____/____/____
MM DD YYYY

7. Sex
☐ Male ☐ Female

8. Ethnicity
☐ Not Spanish/Hispanic/Latino ☐ Hispanic, Mexican, Mexican American, Chicano ☐ Hispanic, Puerto Rican
☐ Hispanic, Cuban ☐ Other Spanish/Hispanic/Latino

9. Race *(Check all that apply)*
☐ White ☐ Far East Asian ☐ Native Hawaiian ☐ Unknown
☐ Black or African American ☐ South East Asian ☐ Other Pacific Islander
☐ American Indian/Alaska Native ☐ Indian Sub-continent ☐ Other

10. Is patient applying for ESRD Medicare coverage?
☐ Yes ☐ No

11. Primary Cause of Renal Failure *(Use code from back of form)*

12. Medical Coverage *(Check all that apply)*
☐ Medicaid ☐ Medicare ☐ Employer Group Health Insurance
☐ DVA ☐ Other ☐ None

13. Height
INCHES _____ OR
CENTIMETERS _____

14. Dry Weight
POUNDS _____ OR
KILOGRAMS _____

15. Employment Status *(6 mos prior and current status)*

Prior	Current	
☐	☐	Unemployed
☐	☐	Employed Full Time
☐	☐	Employed Part Time
☐	☐	Homemaker
☐	☐	Retired due to Age/Preference
☐	☐	Retired (Disability)
☐	☐	Medical Leave of Absence
☐	☐	Student

16. Co-Morbid Conditions *(Check all that apply currently and/or during last 10 years)* *See instructions

a. ☐ Congestive heart failure
b. ☐ Atherosclerotic heart disease ASHD
c. ☐ Other cardiac disease
d. ☐ Cerebrovascular disease, CVA, TIA*
e. ☐ Peripheral vascular disease*.
f. ☐ History of hypertension
g. ☐ Amputation
h. ☐ Diabetes, currently on insulin
i. ☐ Diabetes, on oral medications
j. ☐ Diabetes, without medications
k. ☐ Diabetic retinopathy
l. ☐ Chronic obstructive pulmonary disease
m. ☐ Tobacco use (current smoker)
n. ☐ Malignant neoplasm, Cancer
o. ☐ Alcohol dependence
p. ☐ Drug dependence*
q. ☐ Inability to ambulate
r. ☐ Inability to transfer
s. ☐ Toxic nephropathy
t. ☐ Needs assistance with daily activities
u. ☐ Institutionalized
☐ 1. Assisted Living ☐ 2. Nursing Home
☐ 3. Other Institution
v. ☐ None

17. Prior to ESRD therapy:

a. Did patient receive exogenous erythropoetin or equivalent?	☐ No	☐ < 1 month	☐ 1-6 months	☐ > 6 months	☐ Unknown
b. Was patient under care of renal specialist?	☐ No	☐ < 1 month	☐ 1-6 months	☐ > 6 months	☐ Unknown
c. Did patient have fistula or graft constructed?	☐ No	☐ < 1 month	☐ 1-6 months	☐ > 6 months	☐ Unknown
d. Was patient under care of renal dietitian?	☐ No	☐ < 1 month	☐ 1-6 months	☐ > 6 months	☐ Unknown

18. Laboratory Values Within **45** Days of the Most Recent ESRD Episode. (Lipid Profile within 1 Year of Most Recent ESRD Episode).

LABORATORY TEST	VALUE	DATE	LABORATORY TEST	VALUE	DATE
a.1. Serum Albumin (g/dl)	___ ___ . ___		d. Lipid Profile		
a.2. Serum Albumin Lower Limit			TC	___ ___ . ___	
a.3. Lab Method Used (BCG or BCP)			LDL	___ ___ . ___	
b. Serum Creatinine (mg/dl)	___ ___ . ___		HDL	___ ___ . ___	
c. Hemoglobin (g/dl)*	___ ___ . ___		TG	___ ___ . ___	

B. COMPLETE FOR ALL ESRD PATIENTS IN DIALYSIS TREATMENT

19. Name of Dialysis Facility

20. Medicare Provider Number *(for item 19)*

21. Primary Dialysis Setting
☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

22. Primary Type of Dialysis
☐ Hemodialysis (Sessions per week____/hours per session____)
☐ IPD ☐ CAPD ☐ CCPD ☐ Other

23. Date Regular Chronic Dialysis Began
____/____/____
MM DD YYYY

24. Date Patient Started Chronic Dialysis at Current Facility
____/____/____
MM DD YYYY

25. Has patient been informed of kidney transplant options?
☐ Yes ☐ No

26. If not, please check all that apply:
☐ Medically unfit ☐ Patient declines information
☐ Unsuitable due to age ☐ Patient has not been assessed
☐ Psychologically unfit ☐ Other

C. COMPLETE FOR ALL KIDNEY TRANSPLANT PATIENTS

27. Date of Transplant MM / DD / YYYY	28. Name of Transplant Hospital	29. Medicare Provider Number for Item 28

Date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of actual transplantation.

30. Enter Date MM / DD / YYYY	31. Name of Preparation Hospital	32. Medicare Provider number for Item 31

33. Current Status of Transplant *(if functioning, skip items 35 and 36)* ☐ Functioning ☐ Non-Functioning	34. Type of Donor: ☐ Cadaveric ☐ Living Related ☐ Living Unrelated
35. If Non-Functioning, Date of Return to Regular Dialysis MM / DD / YYYY	36. Current Dialysis Treatment Site ☐ Home ☐ Dialysis Facility/Center ☐ SNF/Long Term Care Facility

D. COMPLETE FOR ALL ESRD SELF-DIALYSIS TRAINING PATIENTS (MEDICARE APPLICANTS ONLY)

37. Name of Training Provider	38. Medicare Provider Number of Training Provider (for Item 37)
39. Date Training Began MM / DD / YYYY	40. Type of Training ☐ Hemodialysis a. ☐ Home b. ☐ In Center ☐ IPD ☐ CAPD ☐ CCPD
41. This Patient is Expected to Complete *(or has completed)* Training and will Self-dialyze on a Regular Basis. ☐ Yes ☐ No	42. Date When Patient Completed, or is Expected to Complete, Training MM / DD / YYYY

I certify that the above self-dialysis training information is correct and is based on consideration of all pertinent medical, psychological, and sociological factors as reflected in records kept by this training facility.

43. Printed Name and Signature of Physician personally familiar with the patient's training a.) Printed Name b.) Signature c.) Date MM / DD / YYYY	44. UPIN of Physician in Item 43

E. PHYSICIAN IDENTIFICATION

45. Attending Physician *(Print)*	46. Physician's Phone No. ( )	47. UPIN of Physician in Item 45

PHYSICIAN ATTESTATION

I certify, under penalty of perjury, that the information on this form is correct to the best of my knowledge and belief. Based on diagnostic tests and laboratory findings, I further certify that this patient has reached the stage of renal impairment that appears irreversible and permanent and requires a regular course of dialysis or kidney transplant to maintain life. I understand that this information is intended for use in establishing the patient's entitlement to Medicare benefits and that any falsification, misrepresentation, or concealment of essential information may subject me to fine, imprisonment, civil penalty, or other civil sanctions under applicable Federal laws.

48. Attending Physician's Signature of Attestation *(Same as Item 45)*	49. Date MM / DD / YYYY

50. Remarks

F. OBTAIN SIGNATURE FROM PATIENT

I hereby authorize any physician, hospital, agency, or other organization to disclose any medical records or other information about my medical condition to the Department of Health and Human Services for purposes of reviewing my application for Medicare entitlement under the Social Security Act and/or for scientific research.

51. Signature of Patient *(Signature by mark must be witnessed.)*	52. Date MM / DD / YYYY

G. PRIVACY STATEMENT

The collection of this information is authorized by Section 226A of the Social Security Act. The information provided will be used to determine if an individual is entitled to Medicare under the End Stage Renal Disease provisions of the law. The information will be maintained in system No. 09-70-0520, "End Stage Renal Disease Program Management and Medical Information System (ESRD PMMIS)" , published in the Privacy Act Issuance, 1991 Compilation, Vol. 1, pages 436-437, December 31, 1991 or as updated and republished. Collection of your Social Security number is authorized by Executive Order 9397. Furnishing the information on this form is voluntary, but failure to do so may result in denial of Medicare benefits. Information from the ESRD PMMIS may be given to a congressional office in response to an inquiry from the congressional office made at the request of the individual; an individual or organization for research, demonstration, evaluation, or epidemiologic project related to the prevention of disease or disability, or the restoration or maintenance of health. Additional disclosures may be found in the *Federal Register* notice cited above. You should be aware that P.L. 100-503, the Computer Matching and Privacy Protection Act of 1988, permits the government to verify information by way of computer matches.

LIST OF PRIMARY CAUSES OF END STAGE RENAL DISEASE

Item 12. Primary Cause of Renal Failure should be completed by the attending physician from the list below. Enter the ICD-9-CM code plus the letter code to indicate the primary cause of end stage renal disease. If there are several probable causes of renal failure, choose one as primary.

ICD-9	LTR	NARRATIVE
DIABETES		
25000	A	Type II, adult-onset type or unspecified type diabetes
25001	A	Type I, juvenile type, ketosis prone diabetes
GLOMERULONEPHRITIS		
5829	A	Glomerulonephritis (GN) (histologically not examined)
5821	A	Focal glomerulosclerosis, focal sclerosing GN
5831	A	Membranous nephropathy
5832	A	Membranoproliferative GN type 1, diffuse MPGN
5832	C	Dense deposit disease, MPGN type 2
58381	B	IgA nephropathy, Berger's disease (proven by immunofluorescence)
58381	C	IgM nephropathy (proven by immunofluorescence)
5804	B	Rapidly progressive GN
5834	C	Goodpasture's syndrome
5800	C	Post infectious GN, SBE
5820	A	Other proliferative GN
SECONDARY GN/VASCULITIS		
7100	E	Lupus erythematosus, (SLE nephritis)
2870	A	Henoch-Schonlein syndrome
7101	B	Scleroderma
28311	A	Hemolytic uremic syndrome
4460	C	Polyarteritis
4464	B	Wegener's granulomatosis
5839	C	Nephropathy due to heroin abuse and related drugs
44620	A	Other Vasculitis and its derivatives
44621	A	Goodpasture's syndrome
5839	B	Secondary GN, other
INTERSTITIAL NEPHRITIS/PYELONEPHRITIS		
9659	A	Analgesic abuse
5830	B	Radiation nephritis
9849	A	Lead nephropathy
5909	A	Nephropathy caused by other agents
27410	A	Gouty nephropathy
5920	C	Nephrolithiasis
5996	A	Acquired obstructive uropathy
5900	A	Chronic pyelonephritis, reflux nephropathy
58389	B	Chronic interstitial nephritis
58089	A	Acute interstitial nephritis
5929	B	Urolithiasis
27549	A	Nephrocalcinosis
HYPERTENSION/LARGE VESSEL DISEASE		
40391	D	Renal disease due to hypertension (no primary renal disease)
4401	A	Renal artery stenosis
59381	B	Renal artery occlusion
59381	E	Cholesterol emboli, renal emboli
CYSTIC/HEREDITARY/CONGENITAL DISEASES		
75313	A	Polycystic kidneys, adult type (dominant)
75314	A	Polycystic, infantile (recessive)
75316	A	Medullary cystic disease, including nephronophthisis
7595	A	Tuberous sclerosis
7598	A	Hereditary nephritis, Alport's syndrome
2700	A	Cystinosis
2718	B	Primary oxalosis
2727	A	Fabry's disease
7533	A	Congenital nephrotic syndrome
5839	D	Drash syndrome, mesangial sclerosis
75321	A	Congenital obstruction of ureterpelvic junction
75322	A	Congenital obstruction of uretrovesical junction
75329	A	Other Congenital obstructive uropathy
7530	B	Renal hypoplasia, dysplasia, oligonephronia
75671	A	Prune belly syndrome
75989	B	Hereditary/familial nephropathy
NEOPLASMS/TUMORS		
1890	B	Renal tumor (malignant)
1899	A	Urinary tract tumor (malignant)
2230	A	Renal tumor (benign)
2239	A	Urinary tract tumor (benign)
2395	A	Renal tumor (unspecified)
2395	B	Urinary tract tumor (unspecified)
20280	A	Lymphoma of kidneys
20300	A	Multiple myeloma
2030	B	Light chain nephropathy
2773	A	Amyloidosis
99680	A	Complications of other transplant
99685	A	Complications of transplanted bone marrow
MISCELLANEOUS CONDITIONS		
28260	A	Sickle cell disease/anemia
28269	A	Sickle cell trait and other sickle cell (HbS/Hb other)
64620	A	Post partum renal failure
0429	A	AIDS nephropathy
8660	A	Traumatic or surgical loss of kidney(s)
5724	A	Hepatorenal syndrome
5836	A	Tubular necrosis (no recovery)
59389	A	Other renal disorders
7999	A	Etiology uncertain

INSTRUCTIONS FOR COMPLETION OF END STAGE RENAL DISEASE MEDICAL EVIDENCE REPORT MEDICARE ENTITLEMENT AND/OR PATIENT REGISTRATION

For whom should this form be completed:

This form **SHOULD NOT** be completed for those patients who are in acute renal failure. Acute renal failure is a condition in which kidney function can be expected to recover after a short period of dialysis, i.e., several weeks or months.

This form **MUST BE** completed within 45 days for **ALL** patients beginning any of the following:

Check the appropriate block that identifies the reason for submission of this form.

Initial ESRD

For all patients who initially receive a kidney transplant instead of a course of dialysis.

All patients for whom a regular course of dialysis has been prescribed by a physician because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life. The first date of a regular course of dialysis is the date this prescription is implemented whether as an inpatient of a hospital, an outpatient in a dialysis center or facility, or a home patient. The form should be completed for all patients in this category even if the patient dies within this time period.

Re-entitlement

For beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

For beneficiaries who stopped dialysis for more than 12 months, have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant. These patients will be reapplying for Medicare ESRD benefits.

Supplemental

Patient has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

All Items except as follows: To be completed by the attending physician, head nurse, or social worker involved in this patient's treatment of renal disease

Items 11, 16, 48-49: To be completed by the attending physician.
Item 43: To be signed by the attending physician or the physician familiar with the patient's self-care dialysis training.
I**tems 51 and 52**: To be signed and dated by the patient.

1. Enter the patient's legal name (Last, first, middle initial). Name should appear exactly the same as it appears on patient's social security or Medicare card.
2. If the patient is covered by Medicare, enter his/her Health Insurance Claim Number as it appears on his/her Medicare card. This number can be verified from his/her Medicare card.
3. Enter the patient's own social security number. This number can be verified from his/her social security card.
4. Enter the patient's mailing address (number and street or post office box number, city, state, and ZIP code.)
5. Enter the patient's home area code and telephone number.
6. Enter patient's date of birth (2-digit Month, Day, and 4-digit Year). Example 07/25/1950.
7. Check the appropriate block to identify sex.
8. Check the appropriate block to identify ethnicity. Definitions of the ethnicity categories for Federal statistics are as follows:

   Not Hispanic or Latino—A person of culture or origin not described below, regardless of race.

   Hispanic, Mexican, Mexican American, Chicano—A person of Mexican culture or origin, regardless of race.

   Hispanic, Cuban—A person of Cuban culture or origin, regardless of race.

   Hispanic, Puerto Rican—A person of Puerto Rican culture or origin, regardless of race.

   Other Spanish/Hispanic/Latino—A person of North, Central or South America, or Caribbean whose language is Spanish and other Spanish culture or origin not described above, regardless of race. **Excluded** are people born in Europe whose language is Spanish or Portuguese, and non-Spanish speaking people born in Brazil, Belize, French Guyana, Guyana and Surinam.
9. Check the appropriate block(s) to identify race. Definitions of the racial categories for Federal statistics are as follows:

   White—A person having origins in any of the original white peoples of Europe.

   Black or African American—A person having origins in any of the black racial groups of Africa. This includes native-born Black Americans, Africans, Haitians and residents of non-Spanish speaking Caribbean Islands of African descent.

   American Indian/Alaska Native—A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

   Far East Asian—A person having origins in any of the original peoples of China, Japan, Korea, Bhutan or other Far East Asia regions.

   Southeast Asian—A person having origins in any of the original peoples of Vietnam, Cambodia, Laos, Thailand, the Philippine Islands and other Southeast Asian regions.

   Indian Sub-continent—A person having origins in any of the original peoples of India, Pakistan, Indonesia, and other Indian sub-continent regions.

DISTRIBUTION OF COPIES:

- Forward the first part (blue) of this form to the Social Security office servicing the claim.
- Forward the second part (green) of this form to the ESRD Network Coordinating Council.
- Retain the last part (white) in the patient's medical records file.

Native Hawaiian—A person having origins in any of the original peoples of the Hawaiian Islands.

Other Pacific Islander— A person having origins in any of the original peoples of the Pacific Islands of Guam, Samoa, Chamarro, Fiji, Polynesia, Tahiti, Micronesia, Tonga the Marshals and other Pacific Islanders.

Other— A person not having origins in any of the above categories.

Unknown—Check this block if race is unknown.

10. Check the appropriate yes or no block to indicate if patient is applying for ESRD Medicare. Note: Even though a person may already be entitled to general Medicare coverage, he/she should re-apply for ESRD Medicare coverage.

11. **To be completed by the attending physician**. Enter the ICD-9-CM plus letter code from back of form to indicate the primary cause of end stage renal disease. These are the only acceptable causes of end stage renal disease.

12. Check **all** the blocks that apply to this patient's current medical insurance status.

    Medicaid—Patient is currently receiving State Medicaid benefits.

    Medicare—Patient is currently entitled to Federal Medicare benefits.

    Employer Group Health Insurance—Patient receives medical benefits through an employee health plan that covers employees, former employees, or the families of employees or former employees.

    DVA—Patient is receiving medical care from a Department of Veterans Affairs facility.

    Other Medical Insurance—Patient is receiving medical benefits under a health insurance plan that is not Medicare, Medicaid, Department of Veterans Affairs, nor an employer group health insurance plan. Examples of other medical insurance are Railroad Retirement and CHAMPUS beneficiaries.

    None—Patient has no medical insurance plan.

13. Enter the patient's most recent recorded height in inches **OR** centimeters at time form is being completed. If entering height in centimeters, round to the nearest centimeter. Estimate or use last known height for those unable to be measured. (Example of inches - 62. DO NOT PUT 5'2") NOTE: For amputee patients, enter height prior to amputation.

14. Enter the patient's most recent recorded dry weight in pounds **OR** kilograms at time form is being completed. If entering weight in kilograms, round to the nearest kilogram.

NOTE: For amputee patients, enter actual dry weight.

15. Check the first box to indicate employment status 6 months prior to renal failure and the second box to indicate current employment status. **Check only one box for each time period**. If patient is under 6 years of age, leave blank.

16. **To be completed by the attending physician**. Check all co-morbid conditions that apply.

    ***Cerebrovascular Disease** includes history of stroke/ cerebrovascular accident (CVA) and transient ischemic attack (TIA).

    ***Peripheral Vascular Disease** includes absent foot pulses, prior typical claudication, amputations for vascular disease, gangrene and aortic aneurysm.

    ***Drug dependence** means dependent on illicit drugs.

17. In 6 months prior to ESRD therapy, check the appropriate box to indicate whether the patient received Exogenous erythropoetin (EPO) or equivalent, was under the care of a renal specialist, had a fistula or graft constructed and was under the care of a renal dietitian.

NOTE: For those patients re-entering the Medicare program after benefits were terminated, Items 18a thru 18d should contain initial laboratory values within 45 days of the most recent ESRD episode.

18a1. Enter the serum albumin value (g/dl) and date test was taken. This value and date must be within 45 days prior to first dialysis treatment or transplant.

18a2. Enter the lower limit of the normal range for serum albumin (g/dl) from the laboratory which performed the serum albumin test entered in 18a.1.

18a3. Enter the serum albumin lab method used (BCG or BCP).

18b. Enter the serum creatinine value (mg/dl) and date test was taken. **THIS FIELD MUST BE COMPLETED.**

18c. Enter the hemoglobin value (g/dl) and date test was taken. This value and date must be within 45 days prior to the first dialysis treatment or kidney transplant.

18d. Enter the Lipid Profile values and date test was taken. These values: TC–Total Cholesterol; LDL–LDL Cholesterol; HDL–HDL Cholesterol; TG–Triglycerides, and date must be within 1 year prior to the first dialysis treatment or kidney transplant.

19. Enter the name of the dialysis facility where patient is currently receiving care and who is completing this form for patient.

20. Enter the 6-digit Medicare identification code of the dialysis facility in item 19.

21. If a person is receiving a regular course of dialysis treatment, check the appropriate **anticipated long term treatment setting** at the time this form is being completed. If a patient is a resident of and receives their dialysis in an intermediate care facility or nursing home, check home.

22. If the patient is, or was, on regular dialysis, **check the anticipated long-term primary type of dialysis**: Hemodialysis, (enter the number of sessions prescribed per week and the hours that were prescribed for each session), IPD (Intermittent Peritoneal Dialysis), CAPD (Continuous Ambulatory Peritoneal Dialysis), CCPD (Continuous Cycle Peritoneal Dialysis), or Other. **Check only one block**. NOTE: Other has been placed on this form to be used only if a new method of dialysis is developed prior to the renewal of this form by Office of Management and Budget.

23. Enter the date (month, day, year) that a "regular course of dialysis" began. The beginning of the course of dialysis is counted from the beginning of regularly scheduled dialysis necessary for the treatment of end stage renal disease (ESRD regardless of the dialysis setting. The date of the first dialysis treatment after the physician has determined that this patient has ESRD and has written a prescription for a "regular course of dialysis" is the "Date Regular Dialysis Began" regardless of whether this prescription was implemented in a hospital/ inpatient, outpatient, or home setting and regardless of any acute treatments received prior to the implementation of the prescription.

NOTE: For these purposes, end stage renal disease means irreversible damage to a person's kidneys so severely affecting his/her ability to remove or adjust blood wastes that in order to maintain life he or she must have either a course of dialysis of a kidney transplant to maintain life.

If re-entering the Medicare program, enter beginning date of the current ESRD episode. Note in Remarks, Item 50, that patient is restarting dialysis.

24. Enter date patient started chronic dialysis at current facility of dialysis services. In cases where patient transferred to current dialysis facility, this date will be after the date in Item 23.

25. Enter whether the patient has been informed of their options for receiving a kidney transplant.

26. If the answer to Item 25 is "No", **check all that apply** for the reasons why the patient was not informed of their kidney transplant options.

27. Enter the date(s) of the patient's kidney transplant(s). If reentering the Medicare program, enter current transplant date.

28. Enter the name of the hospital where the patient received a kidney transplant on the date in Item 27.

29. Enter the 6-digit Medicare identification code of the hospital in Item 28 where the patient received a kidney transplant on the date entered in Item 27.

30. Enter date patient was admitted as an inpatient to a hospital in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation. This includes hospitalization for transplant workup in order to place the patient on a transplant waiting list.

31. Enter the name of the hospital where patient was admitted as an inpatient in preparation for, or anticipation of, a kidney transplant prior to the date of the actual transplantation.

32. Enter the 6-digit Medicare identification number for hospital in Item 31.

33. Check the appropriate functioning or non-functioning block.

34. Enter the type of kidney transplant organ donor, Cadaveric, Living Related or Living Unrelated, that was provided to the patient.

35. If transplant is nonfunctioning, enter date patient returned to a regular course of dialysis. If patient did not stop dialysis post transplant, enter transplant date.

36. If applicable, check where patient is receiving dialysis treatment following transplant rejection. A nursing home or skilled nursing facility is considered as home setting.

Self-dialysis Training Patients (Medicare Applicants Only)

Normally, Medicare entitlement begins with the third month after the month a patient begins a regular course of dialysis treatment. This 3-month qualifying period may be waived if a patient begins a self-dialysis training program in a Medicare approved training facility and is expected to self-dialyze after the completion of the training program. Please complete items 37-42 if the patient has entered into a self-dialysis training program. Items 37-42 must be completed if the patient is applying for a Medicare waiver of the 3-month qualifying period for dialysis benefits based on participation in a self-care dialysis training program.

37. Enter the name of the provider furnishing self-care dialysis training.

38. Enter the 6-digit Medicare identification number for the training provider in Item 36.

39. Enter the date self-dialysis training began. (While it is expect that this date will be after the date patient started a regular course of dialysis, it should not be more than 30 days prior to the start of a regular course of dialysis.)

40. Check the appropriate block which describes the type of self-care dialysis training the patient began. If the patient trained for hemodialysis, enter whether the training was to perform dialysis in the home setting or in the facility (in center).

41. Check the appropriate block as to whether or not the physician certifies that the patient is expected to complete the training successfully and self-dialyze on a regular basis.

42. Enter date patient completed or is expected to complete self-dialysis training.

43. Enter printed name and signature of the attending physician or the physician familiar with the patient's self-care dialysis training.

44. Unique Physician Identification Number (UPIN) of physician in Item 43. (See Item 47 for explanation of UPIN.)

45. Enter the name of the physician who is supervising the patient's renal treatment at the time this form is completed.

46. Enter the area code and telephone number of the physician who is supervising the patient's renal treatment at the time this form is completed.

47. Enter the physician's UPIN assigned by CMS.

    A system of physician identifiers is mandated by Section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985. It requires a unique identifier for each physician who provides services for which Medicare payment is made. An identifier is assigned to each physician regardless of his or her practice configuration. The UPIN is established in a national Registry of Medicare Physician Identification and Eligibility Records (MPIER). Transamerica Occidental Life Insurance Company is the Registry Carrier that establishes and maintains the national registry of physicians receiving Part B Medicare payment. Its address is: UPIN Registry, Transamerica Occidental Life, P.O. Box 2575, Los Angeles, CA 90051-0575.

48. To be signed by the physician supervising the patient's kidney treatment. Signature of physician identified in Item 45. A stamped signature is unacceptable.

49. Enter date physician signed this form.

50. This remarks section may be used for any necessary comments by either the physician, patient, ESRD Network or social security field office.

51. The patient's signature authorizing the release of information to the Department of Health and Human Services must be secured here. If the patient is unable to sign the form, it should be signed by a relative, a person assuming responsibility for the patient or by a survivor.

52. The date patient signed form.

NOTICE

This form is to be completed for all End Stage Renal Disease patients beginning Month 00, 2003, regardless of when the patient started dialysis or received a kidney transplant. Prior blank versions of this form should be destroyed. Old versions of the CMS-2728 will not be accepted by the Social Security Administration or the ESRD Network Coordinating Councils after Month 00, 0000.